

6268

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) John First Barrett Middle Barrett Last		4. DATE OF DEATH Jun. 22, 1956 Month Jun. Day 22 Year 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May II, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Barrett		14. MOTHER'S MAIDEN NAME Mary Graves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. don't know	
17. INFORMANT Hospital Records Address Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO Arterial hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene - all toes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20 , 19 56 , to June 22 , 19 56 , that I last saw the deceased alive on June 22 , 19 56 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED June 23, 1956	
PHYSICIAN'S NAME (Type) Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 25, 1956	22c. NAME OF CEMETERY OR CREMATORY Pomona (Col.) Cem.	22d. LOCATION (City, town, or county) (State) Chestertown. Md.
23. FUNERAL DIRECTOR'S SIGNATURE James Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR June 26-56 24b. REGISTRAR'S SIGNATURE Charles L. Barnes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1958

BUREAU V. 5

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6269

CERTIFICATE OF DEATH

06259

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				c. LENGTH OF STAY IN b. 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS Butlertown			
3. NAME OF DECEASED (Type or print) DENNIS BUTLER				4. DATE OF DEATH Fri. June 22 19 56			
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3 1911	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Butler				14. MOTHER'S MAIDEN NAME Mary Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-9882		17. INFORMANT Mr. Ernest Butler, Worton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure + Uremia DUE TO (b) Hypertension DUE TO (c) Syphilitic (Cardio Vascular) Late Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 023X							INTERVAL BETWEEN ONSET AND DEATH 6 Month Unknown 25 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/11 , 19 56 , to 6/22 , 19 56 , that I last saw the deceased alive on 6/21 , 19 56 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown DATE SIGNED 6/22/56							
ACTUAL SIGNATURE Thomas J. Solon				PHYSICIAN'S NAME (Type) THOMAS J. SOLON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56		22c. NAME OF CEMETERY OR CREMATORY Butlertown Cemetery		22d. LOCATION (City, town, or county) (State) Worton Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.				24. REC'D BY REGISTRAR June 26-1956		24b. REGISTRAR'S SIGNATURE Class L. Barnes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF OTHER OFFICIALS			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06260

201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond - rural</u>		c. LENGTH OF STAY IN 1b <u>Worton, Md. Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES ALLEN DORSEY</u>		4. DATE OF DEATH Month Day Year <u>JUNE 24 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16, 1940</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Albert S. DORSEY</u>		14. MOTHER'S MAIDEN NAME <u>OLIVIA SAMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-362597</u>	
17. INFORMANT <u>Charles Dorsey, Worton, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>after-minute</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>was swimming in pond and didn't come to top. Pulled out about 1/2 hour later</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18) <u>was swimming in pond and didn't come to top. Pulled out about 1/2 hour later</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> a.m. <u>6-24</u> 19 <u>56</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Still Pond Kent Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ROBERT W. FARR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/24/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-28-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FOUNTAIN CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>WORTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>6/25/56</u>		24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased [Faint handwritten text]		2. Sex [Faint handwritten text]	
3. Age [Faint handwritten text]		4. Date of Birth [Faint handwritten text]	
5. Place of Birth [Faint handwritten text]		6. Date of Death [Faint handwritten text]	
7. Cause of Death [Faint handwritten text]		8. Manner of Death [Faint handwritten text]	
9. Signature of Medical Examiner [Faint handwritten signature]		10. Signature of Coroner [Faint handwritten signature]	
11. Signature of Physician [Faint handwritten signature]		12. Signature of Police Officer [Faint handwritten signature]	
13. Signature of [Faint handwritten text]		14. Signature of [Faint handwritten text]	
15. Signature of [Faint handwritten text]		16. Signature of [Faint handwritten text]	
17. Signature of [Faint handwritten text]		18. Signature of [Faint handwritten text]	
19. Signature of [Faint handwritten text]		20. Signature of [Faint handwritten text]	
21. Signature of [Faint handwritten text]		22. Signature of [Faint handwritten text]	
23. Signature of [Faint handwritten text]		24. Signature of [Faint handwritten text]	
25. Signature of [Faint handwritten text]		26. Signature of [Faint handwritten text]	
27. Signature of [Faint handwritten text]		28. Signature of [Faint handwritten text]	
29. Signature of [Faint handwritten text]		30. Signature of [Faint handwritten text]	
31. Signature of [Faint handwritten text]		32. Signature of [Faint handwritten text]	
33. Signature of [Faint handwritten text]		34. Signature of [Faint handwritten text]	
35. Signature of [Faint handwritten text]		36. Signature of [Faint handwritten text]	
37. Signature of [Faint handwritten text]		38. Signature of [Faint handwritten text]	
39. Signature of [Faint handwritten text]		40. Signature of [Faint handwritten text]	
41. Signature of [Faint handwritten text]		42. Signature of [Faint handwritten text]	
43. Signature of [Faint handwritten text]		44. Signature of [Faint handwritten text]	
45. Signature of [Faint handwritten text]		46. Signature of [Faint handwritten text]	
47. Signature of [Faint handwritten text]		48. Signature of [Faint handwritten text]	
49. Signature of [Faint handwritten text]		50. Signature of [Faint handwritten text]	
51. Signature of [Faint handwritten text]		52. Signature of [Faint handwritten text]	
53. Signature of [Faint handwritten text]		54. Signature of [Faint handwritten text]	
55. Signature of [Faint handwritten text]		56. Signature of [Faint handwritten text]	
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59. Signature of [Faint handwritten text]		60. Signature of [Faint handwritten text]	
61. Signature of [Faint handwritten text]		62. Signature of [Faint handwritten text]	
63. Signature of [Faint handwritten text]		64. Signature of [Faint handwritten text]	
65. Signature of [Faint handwritten text]		66. Signature of [Faint handwritten text]	
67. Signature of [Faint handwritten text]		68. Signature of [Faint handwritten text]	
69. Signature of [Faint handwritten text]		70. Signature of [Faint handwritten text]	
71. Signature of [Faint handwritten text]		72. Signature of [Faint handwritten text]	
73. Signature of [Faint handwritten text]		74. Signature of [Faint handwritten text]	
75. Signature of [Faint handwritten text]		76. Signature of [Faint handwritten text]	
77. Signature of [Faint handwritten text]		78. Signature of [Faint handwritten text]	
79. Signature of [Faint handwritten text]		80. Signature of [Faint handwritten text]	
81. Signature of [Faint handwritten text]		82. Signature of [Faint handwritten text]	
83. Signature of [Faint handwritten text]		84. Signature of [Faint handwritten text]	
85. Signature of [Faint handwritten text]		86. Signature of [Faint handwritten text]	
87. Signature of [Faint handwritten text]		88. Signature of [Faint handwritten text]	
89. Signature of [Faint handwritten text]		90. Signature of [Faint handwritten text]	
91. Signature of [Faint handwritten text]		92. Signature of [Faint handwritten text]	
93. Signature of [Faint handwritten text]		94. Signature of [Faint handwritten text]	
95. Signature of [Faint handwritten text]		96. Signature of [Faint handwritten text]	
97. Signature of [Faint handwritten text]		98. Signature of [Faint handwritten text]	
99. Signature of [Faint handwritten text]		100. Signature of [Faint handwritten text]	

BUREAU V. 3

JUN 26 1956

RECEIVED

6271

CERTIFICATE OF DEATH

Reg. Dist. No. *2102*

1. PLACE OF DEATH a. COUNTY <i>KENT</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>KENT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>KENT QUEEN HOSP.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>EFFIE</i> First <i>M</i> Middle <i>HUDSON</i> Last		4. DATE OF DEATH <i>June 11 1956</i> Month <i>June</i> Day <i>11</i> Year <i>1956</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 21-1879</i> 76 yrs.
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS CROUCH</i>		14. MOTHER'S MAIDEN NAME <i>JANE COLEMAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs George Kelly</i> Address <i>Rock Hall</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease & coronary insufficiency</i> DUE TO (c) <i>5 years +</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 52</i> to <i>June 11 1956</i> , that I last saw the deceased alive on <i>June 11 1956</i> , and that death occurred at <i>7:35 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Rock Hall, Md</i> DATE SIGNED <i>6/11/56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>June 13</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Rock Hall Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i> ADDRESS <i>Church Hill</i>		24a. REC'D BY REGISTRAR <i>June 14-56</i>	24b. REGISTRAR'S SIGNATURE <i>Clara L. Barnes</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 18 1956

RECEIVED

6272

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WORTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT-QUEEN ANNE'S HOSP.		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) John W. Mitchell		4. DATE OF DEATH June 15 1956	
5. SEX MALE	6. COLOR OR RACE W.O.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM HAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MITCHELL		14. MOTHER'S MAIDEN NAME ALICE BOWSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertrophy of prostate gland DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH several days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1956 to June 15, 1956 , that I last saw the deceased alive on June 15, 1956 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard J. Smith M.D.		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 6/16/56	
PHYSICIAN'S NAME (Type) WILLARD J. SMITH		ROCK HALL, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/17/56	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET	22d. LOCATION (City, town, or county) (State) WORTON MD.
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy ADDRESS 5711- POND, MD		24a. REC'D BY REGISTRAR DATE 6/18/56	24b. REGISTRAR'S SIGNATURE E. Leonard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 18

NAME OF DECEASED: KENT, JAMES
SEX: M
AGE: 18

DATE OF DEATH: 11-27-51
PLACE OF DEATH: HOME

CAUSE OF DEATH: UNKNOWN

DATE OF BIRTH: 11-27-51
PLACE OF BIRTH: HOME

DATE OF DEATH: 11-27-51
PLACE OF DEATH: HOME

DATE OF DEATH: 11-27-51
PLACE OF DEATH: HOME

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DATE OF DEATH: 11-27-51
PLACE OF DEATH: HOME

RECEIVED
JUN 19 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 66263
6273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>Entire life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Used Car Lot</u>				d. STREET ADDRESS <u>Cross St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HORACE V. NEEDLES</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic (Laborer)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Needles</u>				14. MOTHER'S MAIDEN NAME <u>Emma Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-0100</u>		17. INFORMANT Address <u>Mrs. Frances Needles Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns sustained in fire</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>short time</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found in seat of burning parked auto in car lot</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 6/2/ 1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>used car lot</u>		20f. (City or town) (County) (State) <u>Chestertown Kent Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u> EXAMINER'S NAME (Type) <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/2/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR <u>June 5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Class L. Barnes</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-inquest permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

ARKANSAS STATE DEPARTMENT OF HEALTH - BATTLE ROY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. R.

1956

JUN 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6274

CERTIFICATE OF DEATH

06264

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 2 1/2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ALICE Last O'BRIEN		4. DATE OF DEATH Month JUNE Day 6 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 28, 1875
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD CARR		14. MOTHER'S MAIDEN NAME ELIZ. CALMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT HOSPITAL CHART.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 12 days DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 FRACTURE, RT. HIP			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME.	
20c. TIME OF INJURY Month, Day, Year Hour 9 p. m. MAY 25 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) (County) (State) CHESTERTOWN KENT MD.
21. I certify that I attended the deceased from MAY 25, 1956 , to JUNE 6, 1956 , that I last saw the deceased alive on JUNE 5, 1956 , and that death occurred at 4:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE A. T. Keefe, Jr.		DATE SIGNED 6-6-56	
PHYSICIAN'S NAME (Type) ARTHUR T. KEEFE, JR. M.D.		ADDRESS (Street, city or town, state) CHESTERTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE G. Willis Wells		24a. REC'D BY REGISTRAR June 7-56	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Clara L. Bunker	

MEDICAL CERTIFICATION

14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6279

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown R.D.1</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Orem Farm</u>				STREET ADDRESS (If rural give location) <u>R. D. 1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HIGHLEY DUDLEY OREM</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 13/56</u> 19			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Jan. 20, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Robert Orem</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Coleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-32-0687</u>		17. INFORMANT & ADDRESS <u>Mr. C. Dudley Orem, Chestertown, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Pt. dead on arrival. Last seen alive about 7:00p.m. Consultation with attending physician following day; pt. suffered from coronary artery disease. Death due to circulatory collapse due to c.a.d.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary artery disease. Death due to circulatory collapse due to c.a.d.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6-13</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-13</u> , 19 <u>56</u> , to <u>6-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>56</u> , and that death occurred at <u>6-13</u> , 19 <u>56</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. S. Williams</u>				ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>6-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
24. REC'D BY REGISTRAR <u>June 15-1956</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF MINISTER		15. NAME OF CLERGYMAN	
16. NAME OF FUNERAL HOME		17. NAME OF BURIAL PLACE		18. NAME OF CEMETERY	
19. NAME OF INTERVIEWER		20. NAME OF WITNESS		21. NAME OF SIGNER	
22. NAME OF SIGNER		23. NAME OF SIGNER		24. NAME OF SIGNER	
25. NAME OF SIGNER		26. NAME OF SIGNER		27. NAME OF SIGNER	
28. NAME OF SIGNER		29. NAME OF SIGNER		30. NAME OF SIGNER	
31. NAME OF SIGNER		32. NAME OF SIGNER		33. NAME OF SIGNER	
34. NAME OF SIGNER		35. NAME OF SIGNER		36. NAME OF SIGNER	
37. NAME OF SIGNER		38. NAME OF SIGNER		39. NAME OF SIGNER	
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52. NAME OF SIGNER		53. NAME OF SIGNER		54. NAME OF SIGNER	
55. NAME OF SIGNER		56. NAME OF SIGNER		57. NAME OF SIGNER	
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73. NAME OF SIGNER		74. NAME OF SIGNER		75. NAME OF SIGNER	
76. NAME OF SIGNER		77. NAME OF SIGNER		78. NAME OF SIGNER	
79. NAME OF SIGNER		80. NAME OF SIGNER		81. NAME OF SIGNER	
82. NAME OF SIGNER		83. NAME OF SIGNER		84. NAME OF SIGNER	
85. NAME OF SIGNER		86. NAME OF SIGNER		87. NAME OF SIGNER	
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91. NAME OF SIGNER		92. NAME OF SIGNER		93. NAME OF SIGNER	
94. NAME OF SIGNER		95. NAME OF SIGNER		96. NAME OF SIGNER	
97. NAME OF SIGNER		98. NAME OF SIGNER		99. NAME OF SIGNER	
100. NAME OF SIGNER		101. NAME OF SIGNER		102. NAME OF SIGNER	

BUREAU V. S.

JUN 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6275

CERTIFICATE OF DEATH

06266

Reg. Dist. No. 2082

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>37 Chestertown</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>72 Kent & Queen Anne Hospital</i>		d. STREET ADDRESS <i>Massey</i>	
3. NAME OF DECEASED (Type or print) First <i>MAUDE</i> Middle <i>E</i> Last <i>PEACOCK</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>9</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 21, 1875</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR: Months <i>80</i> Days <i>80</i> Hours <i>80</i> Min. <i>80</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Bramble</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn Wood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Hospital records</i>	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal bronchopneumonia</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive heart failure</i> DUE TO (c) <i>Arterial hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6-8 months</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary thrombosis - about 6 months ago</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-29</i> , 19 <i>56</i> , to <i>6-9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6-9</i> , 19 <i>56</i> , and that death occurred at <i>9:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		ADDRESS (Street, city or town, state) <i>Chestertown, Md.</i> DATE SIGNED <i>6/9/56</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT W. FARR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/12/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MASSEY CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>MASSEY-KENT Co. MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Helms - Millington, Md.</i>		24a. REC'D BY REGISTRAR <i>June 13-56</i> 24b. REGISTRAR'S SIGNATURE <i>Clara S. Barnes</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 10, 1955</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
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43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
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70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
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88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

JUN 15 1955

RECEIVED

6276

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Queen St.</u>	
3. NAME OF DECEASED (Type or print) <u>Emerson Roberts Russell</u>		4. DATE OF DEATH <u>June 20, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904 Oct. 19, 1904</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agency (General)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(General)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>L. Bates Russell, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Iola Kendall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-3970</u>	
17. INFORMANT <u>Harry S. Russell</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalopathy</u> DUE TO <u>Arterior hypertension and probably recurrence of intracranial neoplasm (meningioma)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1946</u> , to <u>June 20, 1956</u> , that I last saw the deceased alive on <u>June 20, 1956</u> , and that death occurred at <u>2:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D.</u>		DATE SIGNED <u>6/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>June 22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director should file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06268

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>46X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> d. STREET ADDRESS <u>1102 West St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB</u> <u>MARTIN</u> <u>SMITH</u>				4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>17</u> <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1933</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 14, 1956</u>		9. AGE (In years last birthday) <u>23</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INS. ADJUSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB SMITH</u>				14. MOTHER'S MAIDEN NAME <u>JULIA V. BOLTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>JACOB SMITH 1102 WEST ST. WILMINGTON, DEL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE SEVERE INJURIES</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TO ALL PORTIONS OF BODY</u> DUE TO (c) <u>NONE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>was thrown from car in auto mobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/17 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 43.213 Kennedyville Kent Md</u>		20f. (City or town) (County) (State) <u>Kennedyville Kent Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				DATE SIGNED <u>6/17/56</u>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRANDYWINE CHURCHYARD</u>		22d. LOCATION (City, town, or county) (State) <u>CHADD'S FORD, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR <u>Edmund Jones</u> DATE <u>6/18/56</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to cremation, or removal.

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6277

CERTIFICATE OF DEATH

06269

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (Edesville)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 72 Kent & Queen Anne Co. Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Warren Last 		4. DATE OF DEATH June II, 1956 Month June Day II Year 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Kent CO. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Warren		14. MOTHER'S MAIDEN NAME Hattie Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) don't know	
17. INFORMANT Melvin Warren		Address Chestertown, Md. RED # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 057.0 Meningitis (meningococcal) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1956 to June 11, 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard F. Smith		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 6/12/56	
PHYSICIAN'S NAME (Type) Willard F. Smith		- Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 13, 1956	22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.	22d. LOCATION (City, town, or county) (State) Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR June 13-56		24b. REGISTRAR'S SIGNATURE Clara L. Barnes	

CERTIFICATE OF DEATH

6577

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. PLACE OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF PHYSICIAN [Faint text]		20. SIGNATURE OF REGISTRAR [Faint text]		21. SIGNATURE OF WITNESS [Faint text]	
22. SIGNATURE OF PHYSICIAN [Faint text]		23. SIGNATURE OF REGISTRAR [Faint text]		24. SIGNATURE OF WITNESS [Faint text]	
25. SIGNATURE OF PHYSICIAN [Faint text]		26. SIGNATURE OF REGISTRAR [Faint text]		27. SIGNATURE OF WITNESS [Faint text]	
28. SIGNATURE OF PHYSICIAN [Faint text]		29. SIGNATURE OF REGISTRAR [Faint text]		30. SIGNATURE OF WITNESS [Faint text]	
31. SIGNATURE OF PHYSICIAN [Faint text]		32. SIGNATURE OF REGISTRAR [Faint text]		33. SIGNATURE OF WITNESS [Faint text]	
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85. SIGNATURE OF PHYSICIAN [Faint text]		86. SIGNATURE OF REGISTRAR [Faint text]		87. SIGNATURE OF WITNESS [Faint text]	
88. SIGNATURE OF PHYSICIAN [Faint text]		89. SIGNATURE OF REGISTRAR [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
91. SIGNATURE OF PHYSICIAN [Faint text]		92. SIGNATURE OF REGISTRAR [Faint text]		93. SIGNATURE OF WITNESS [Faint text]	
94. SIGNATURE OF PHYSICIAN [Faint text]		95. SIGNATURE OF REGISTRAR [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF PHYSICIAN [Faint text]		98. SIGNATURE OF REGISTRAR [Faint text]		99. SIGNATURE OF WITNESS [Faint text]	
100. SIGNATURE OF PHYSICIAN [Faint text]		101. SIGNATURE OF REGISTRAR [Faint text]		102. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. 2

JUN 15 1956

RECEIVED

6278

CERTIFICATE OF DEATH

Reg. Dist. No. 2022

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. LENGTH OF STAY IN 1b <u>3 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne's</u>				d. STREET ADDRESS <u>Millington</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>T</u> Last <u>WILSON</u>				4. DATE OF DEATH Month <u>JUN</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 7 1899</u>	9. AGE (In years (age birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Labor</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM WILSON</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>HOSPITAL CHM</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROSTATIC CARCINOMA.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 21, 1956</u> to <u>JUN 3, 1956</u> ; that I last saw the deceased alive on <u>JUN 3, 1956</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. T. Keefe, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>CHESTER TOWN, Md</u>			
PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR., M.D.</u>				DATE SIGNED <u>6.3.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pike's Neck Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Millington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Pellour</u>				ADDRESS <u>Millington</u>		24a. REC'D BY REGISTRAR DATE <u>6/5/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edward Pellour</u>		6-9-1956 Clara S. Barne	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		M		45		W		1910		BALTIMORE, MD		JUN 12 1956		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF REGISTRAR		14. ADDRESS OF REGISTRAR		15. CITY AND STATE OF REGISTRAR		16. DATE OF REGISTRATION		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF DECEASED		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF BURIAL PLACE		24. SIGNATURE OF CREMATOR	
J. H. HARRIS		1234 E. MAIN ST.		BALTIMORE, MD		JUN 12 1956		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

JUN 12 1956

RECEIVED